Filing at a Glance

Company:	Kanawha Insurance Company
Product Name:	Accident
State:	Arkansas
TOI:	H02I Individual Health - Accident Only
Sub-TOI:	H02I.000 Health - Accident Only
Filing Type:	Form
Date Submitted:	01/22/2013
SERFF Tr Num:	HUMA-128861770
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AR 71111 2012
Implementation Date Requested:	On Approval
Author(s):	Judy Lanning, Nancy Anderson, Glenda Howell
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	01/30/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Kanawha Insurance Company*
TOI/Sub-TOI: *H02I Individual Health - Accident Only/H02I.000 Health - Accident Only*
Product Name: *Accident*
Project Name/Number: *Accident Application 2013/*

General Information

Project Name: Accident Application 2013
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Deemer Date:
Submitted By: Nancy Anderson

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: This form is being filed simultaneously in our domicile state
Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/30/2013
State Status Changed: 01/30/2013
Created By: Nancy Anderson
Corresponding Filing Tracking Number:

Filing Description:

Kanawha Insurance Company is submitting the above captioned form for the Department's review and approval. This form is new and will be used with previously approved
Accident Policy Form No 60680 AR approved on May 3, 2012.

The Accident Insurance Application has been designed for use in the individual market in Direct to Consumer, Agent and /or Broker based distribution channels. Bracketing has been added to support Administrative needs. A Statement of Variability is included under the Supporting Documentation Tab.

The form is in final print, subject to minor variations in formatting, duplexing, shading and fonts.

Company and Contact

Filing Contact Information

Nancy Anderson, Regional Contract Analyst nanderson1@humana.com
500 W. Main Street 502-580-4230 [Phone]
NCT-1
Louisville, KY 40202

Filing Company Information

Kanawha Insurance Company
210 South White Street
Lancaster, SC 29720
(800) 635-4252 ext. [Phone]

CoCode: 65110
Group Code: 119
Group Name:
FEIN Number: 57-0380426

State of Domicile: South Carolina
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50.00 per application form.
Per Company:	No

SERFF Tracking #: *HUMA-128861770* ***State Tracking #:*** ***Company Tracking #:*** *AR 71111 2012*

State: *Arkansas* ***Filing Company:*** *Kanawha Insurance Company*
TOI/Sub-TOI: *H02I Individual Health - Accident Only/H02I.000 Health - Accident Only*
Product Name: *Accident*
Project Name/Number: *Accident Application 2013/*

Company	Amount	Date Processed	Transaction #
Kanawha Insurance Company	$50.00	01/22/2013	66765020

SERFF Tracking #:	*HUMA-128861770*	***State Tracking #:***		***Company Tracking #:***	*AR 71111 2012*

State:	*Arkansas*	***Filing Company:***	*Kanawha Insurance Company*
TOI/Sub-TOI:	*H02I Individual Health - Accident Only/H02I.000 Health - Accident Only*		
Product Name:	*Accident*		
Project Name/Number:	*Accident Application 2013/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/30/2013	01/30/2013

SERFF Tracking #:	*HUMA-128861770*	***State Tracking #:***		***Company Tracking #:***	*AR 71111 2012*

State:	*Arkansas*	***Filing Company:***	*Kanawha Insurance Company*
TOI/Sub-TOI:	*H02I Individual Health - Accident Only/H02I.000 Health - Accident Only*		
Product Name:	*Accident*		
Project Name/Number:	*Accident Application 2013/*		

Disposition

Disposition Date: 01/30/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Accident Insurance Application	Approved-Closed	Yes

SERFF Tracking #:	*HUMA-128861770*	***State Tracking #:***		***Company Tracking #:***	*AR 71111 2012*

State:	*Arkansas*	***Filing Company:***	*Kanawha Insurance Company*
TOI/Sub-TOI:	*H02I Individual Health - Accident Only/H02I.000 Health - Accident Only*		
Product Name:	*Accident*		
Project Name/Number:	*Accident Application 2013/*		

Form Schedule

Lead Form Number: AR-71111 1/2013

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/30/2013	Accident Insurance Application	AR-71111 1/2013	AEF	Initial		40.000	AR-71111_1-2013.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Accident Insurance Application

Accident product is insured by Kanawha Insurance Company, a Humana company

Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

Date of application: _____ **Requested Effective Date:** _____
(Requested Effective Date is Optional - not to exceed 45 calendar days from the date application is signed)

The effective date is assigned by Kanawha. An agent cannot assign an effective date.

Coverage Options **Please complete this section when selecting a policy. [All references of spouse in this application include [domestic partner][/][civil union partner][/][reciprocal beneficiary].]**

Plan Type:		[Benefit Amount _____]
[❑ Individual (adult or child)]	[❑ Single Parent (parent and all children)]	
[❑ Family (2 parents and all children)]	[❑ Couple (individual and spouse)]	

[❑ Benefit Amount $ _____]

[❑ Individual (adult or child) $_____] [❑ Single Parent (parent and all children) $_____]

[❑ Family (2 parents and all children) $_____] [❑ Couple (individual and spouse) $_____]

[❑ Benefit Amount $ _____]

[❑ Individual (adult or child) $_____] [❑ Single Parent (parent and all children) $_____]

[❑ Family (2 parents and all children) $_____] [❑ Couple (individual and spouse) $_____]

[❑ Benefit Amount $_____]

[❑ Individual (adult or child) $_____] [❑ Single Parent (parent and all children) $_____]

[❑ Family (2 parents and all children) $_____] [❑ Couple (individual and spouse) $_____]

[❑ Benefit Amount $_____]

[❑ Individual (adult or child) $_____] [❑ Single Parent (parent and all children) $_____]

[❑ Family (2 parents and all children) $_____] [❑ Couple (individual and spouse) $_____]

Proposed Primary Insured Information

[If child-only coverage is requested, the application must be filled out by parent or legal representative.]

First name	MI	Last name	Suffix	Gender ❑ M ❑ F
Social Security #	Height	Weight	Primary phone #	Secondary phone #
E-mail	[Country or State of birth]		Date of birth	
Home address (not P.O. Box)	City	State	ZIP code	
Mailing address (if different from home address)	City	State	ZIP code	
[Occupation]	[Type of business or industry]			

[Policy Owner] (Parent or Legal Representative) Information: **To be completed if Proposed Primary Insured is a minor.**

First name	MI	Last name	Suffix

Social Security #	E-mail	Date of birth

Mailing address	City	State	ZIP code

Primary phone #	Secondary phone #	Relationship to Proposed Primary Insured

]

Dependent Information **Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.**

Spouse First name	MI	Last name		Suffix
Social Security #	Height	Weight	Gender ❑ M ❑ F	Date of birth
[Country or State of birth]	[Occupation]			[Type of business or industry]
Dependent First name	MI	Last name		Suffix
[Full-time student (if [0-40] or older) ❑ No ❑ Yes]	Height	Weight	Gender ❑ M ❑ F	Date of birth
Dependent First name	MI	Last name		Suffix
[Full-time student (if [0-40] or older) ❑ No ❑ Yes]	Height	Weight	Gender ❑ M ❑ F	Date of birth
Dependent First name	MI	Last name		Suffix
[Full-time student (if [0-40] or older) ❑ No ❑ Yes]	Height	Weight	Gender ❑ M ❑ F	Date of birth

Beneficiary Information **Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated. Benefit percentages must total 100% for the Primary Beneficiary(ies) and also equal 100% for the Contingent Beneficiary(ies).**

Primary beneficiary name	Relationship	Benefit %
Primary beneficiary name	Relationship	Benefit %
Contingent beneficiary name	Relationship	Benefit %

[Existing Coverage

[1. ❑ Yes ❑ No Does any person proposed for coverage have any existing accident insurance coverage in force or an application for similar insurance pending with this or any other company?]

[If yes, please provide details with specific benefit amounts.

Carrier ____________________ Effective Date____________________

Name of the Insured____________________ Benefit Value ____________________

Policy Name____________________ Policy # ____________________]

[2. ❑ Yes ❑ No Will the policy applied for replace any coverage currently in force?]

]

Agreement and Signature

True and Complete Acknowledgment: I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I agree to immediately notify Kanawha of any changes to the information contained in this form that occur prior to the policy effective date. I have received and reviewed any state or federal required disclosures. I acknowledge that neither I nor the agent have the right to waive or incompletely answer any question, determine coverage or insurability, alter any contract, or waive any of Kanawha's other rights and requirements. If this application for coverage is accepted, coverage will be effective on the date specified by Kanawha on the policy. Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the application by Kanawha. Acceptance of premium and fees does not guarantee coverage. Any misrepresentation on this application may be used by Kanawha during the first two policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. [As a parent or legal guardian of a dependent [under the age of] [0-40] year[s] [or older] applying for coverage, I attest by my signature below, that I have gathered the necessary health information regarding my dependent in order to fully and truthfully complete this application.]

[We may use and disclose a covered person's personal information, without consent/authorization, to pay claims. We may collect a covered person's personal information from other Kanawha affiliated companies to pay claims. We may share a covered person's personal information with other Kanawha affiliated companies, as permitted by law. To obtain a list of Kanawha affiliated companies, please visit our website at [Humana.com].]

This document, together with any supplemental forms, will make up part of any contract and be the basis for any policy issued.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you or provide benefits.

Signed at: City_____ State _____

➲ Proposed Primary Insured [or Policy Owner/Legal Representative] Signature

_____ Date _____

[➲ Spouse Signature (if covered dependent)

_____ Date _____]

(Optional)

Agent / Producer Information

This section to be completed by Agent or Producer (if applicable).

Agent / Agency of Record: (for commissions and correspondence)	**Writing Agent / Producer:**
Name (print)	Name (print)
Humana Agent #	Humana Agent #

Agent replacement question:

[Will this policy replace or change any existing accident insurance policy(ies)? ❑ Yes ❑ No]

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the proposed primary insured submitting this application in order to fully and accurately represent the terms and conditions of the policies and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the proposed primary insured in the benefit summary document or other policy literature.

➲ Writing Agent's Signature _____ Date _____

The original version of this application is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

SERFF Tracking #:	*HUMA-128861770*	***State Tracking #:***	***Company Tracking #:*** *AR 71111 2012*

State:	*Arkansas*	***Filing Company:***	*Kanawha Insurance Company*
TOI/Sub-TOI:	*H02I Individual Health - Accident Only/H02I.000 Health - Accident Only*		
Product Name:	*Accident*		
Project Name/Number:	*Accident Application 2013/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
Readability Certification Accident.pdf			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved-Closed	01/30/2013
Bypass Reason:	This filing contains only an application. This is the only form being filed in this submission.		

		Item Status:	**Status Date:**
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/30/2013
Bypass Reason:	No rates are included in this filing and no rates are affected by any provisions of this application.		

		Item Status:	**Status Date:**
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/30/2013
Bypass Reason:	This filing contains only an application. This is the only form being filed in this submission.		

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
AR Application Cover Letter.pdf			

READABILITY CERTIFICATION

Company Name: Kanawha Insurance Company

NAIC Number: 65110
FEIN Number: 57-0380426

Subject: Application, AR-71111 1/2013

As an officer of Kanawha Insurance Company, I hereby certify that the following forms achieve a Flesch score that meets or exceeds requirements as follows:

Form Number	Flesch Score
AR-71111 1/2013	40.0

Bruce Broussard, President

Jan. 22, 2013
Date

HUMANA.
Guidance when you need it most

January 22, 2013

Arkansas Department of Insurance
Jay Bradford, Commissioner
1200 W. 3rd Street
Little Rock, AR 72201-1904

RE: Kanawha Insurance Company
Accident Insurance Application Form AR-71111 1/2013
NAIC COMPANY CODE 65110
FEDERAL TAX ID #57-0380426
NAIC GROUP CODE 000

Dear Commissioner:

Kanawha Insurance Company is submitting the above captioned form for the Department's review and approval. This form is new and will be used with previously approved Accident Policy Form No 60680 AR approved on May 3, 2012.

The Accident Insurance Application has been designed for use in the individual market in Direct to Consumer, Agent and /or Broker based distribution channels. Bracketing has been added to support Administrative needs. A Statement of Variability is included under the Supporting Documentation Tab.

The form is in final print, subject to minor variations in formatting, duplexing, shading and fonts.

Thank you for your attention to this filing. If you should have any questions, please contact me at 502-580-4230. My email address is nanderson1@humana.com.

Sincerely,

Nancy E. Anderson
Compliance Consultant